PRINTED: 06/14/2011 FORM APPROVED OMB NO. 0938-0391

Opportunity of the contract of		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CDRRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	-	
	•	09G160	B. WING		05/2	20/2011
NAME OF P	ROVIDER OR SUPPLIER		78	EET ADDRESS, CITY, STATE, ZIP C 3 53RD PLACE, SE /ASHINGTON, DC 20019	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHDULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	W 000			and the state of t
W 159	5/17/2011 through sampling of three of population of five in of mental and phys.  This re-certification fundamental survey extended in the Collection of the	was initiated utilizing the y process, but had to be ndition of Participation of concerns in nursing practice findings of this survey were ions at the group home and interview with direct care staff and a review of the habilitation records including the unusual	W 159	Department of He Health Regulation & Licensing, Intermediate Care Faciliti 899 North Capitol St Washington, D.C. 2	Administration es Division ., N.E. 0002	612911
	integrated, coordin qualified mental re  This STANDARD Based on observareview, the facility intellectual Disabilicoordinated, integrifor two of the three Clients #1 and #3)  The findings including the facility is Quare Professional (QIDF)	e treatment program must be ated and monitored by a tardation professional.  is not met as evidenced by: tion, staff interview, and record failed to ensure the Qualified ty Professional (QIDP) ated, and monitored services, e clients residing in the facility.  le:  lified Intellectual Disability  P) failed to ensure all staff were to serve meals in the texture				
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	·····	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

COMPLIANCE OUPERIUSOR

Facility ID: 09G160

Event ID: M35E11

If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S COMPL	
	09G160	B. WING		05/2	20/2011
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 07		78	ET ADDRESS, CITY, STATE, ZIP CC 53RD PLACE, SE ASHINGTON, DC 20019	DDE	
PREELY (FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W474) W 189 483.430(e)(1) ST  The facility must initial and continu	ned. (See W189, W460 and AFF TRAINING PROGRAM provide each employee with ing training that enables the form his or her duties effectively,	W 159 W 189	See I 183		612911
Based on obserview, the facility effectively trained mealtime feeding	is not met as evidenced by: vation, staff interview and record valled to ensure all staff were to implement each client's protocol for two of three [Clients #1 and #3]				
revealed, Client # snack of sliced a a cup of fruit pun	2 W474]  /17/2011 beginning at 4:45 p.m.  #1 and Client #3 were served a pples (Granny Smith apple) and ch. The apples appeared firm ch when the client bit into it.				
and physician 's approximately 11 both prescribed a should be noted, mechanically sof Further review re on food texture re Language Pathol	ient's nutritional assessments order on 5/19/2011 at :30 a.m., revealed they were a "chopped" texture diet. It Client #1 was prescribed a "t, chopped texture diet, chopped text				

STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
	09G160	8. WING_		05/2	0/2011
NAME OF PROVIDER OR SU	IPPLIER	7	REET ADDRESS, CITY, STATE, ZIP CI 18 53RD PLACE, SE NASHINGTON, DC 20019	3DE	
PREEIX (EACH DE	MARY STATEMENT OF DEFICIENCIES OF ICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
3:10 p.m. conducted to the deficient evening of she would he to address to ad	rofessional (QIDP) on 5/19/2011, at confirmed, the 4/18/2011 training by the SLP was not effective in light of the practices that took place on the 5/17/2011. The QIDP further indicated are to ensure additional staff training the problem.  failed to ensure all staff was rained to implement Client #1 and #3 feeding protocol and further failed to in clients were provided the correct at.  2) DRUG USAGE  for control of inappropriate behaviored only as an integral part of the evidual program plan that is directed towards the reduction of and eventual of the behaviors for which the drugs ed.  DARD is not met as evidenced by: observation, interview and record facility failed to ensure that the use of codification medications prescribed to redical appointments was incorporated and Program Plan (IPP) for one of a led clients. [Client #1]  includes:  In on the evening of 5/17/2011  lient #1 was on a psychotropic 20 mg of Paroxetine HCL (for ) and 20 mg of Zyprexa	ed 9 312 W 312		hess at 5 the	12/7/10 6/6/1)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G160	B. WING			05/20/2011	
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 07				78	EET ADDRESS, CITY, STATE, ZIP CODE 8 53RD PLACE, SE VASHINGTON, DC 20019		
(X4) ID PREFIX FAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 312	Order Sheets (POS revealed, Client #1 "Lorazepam (Ativat 1 hour prior to procedute read " Lora tab prior to procedute prior to prior	at 's 5/2011 Physician 's 5) on 5/20/2010 at 11:59 a.m. also had a standing order for 1) 2 mg Tablet; 1 tab by mouth redure. "The order goes on to zepam (Ativan) 2 mg Tablet; ½ ure if not sedated. "The was put into effect on age his non-compliance with tments. Additional review of revealed he was sedated on ardiology (EEG) assessment 3/2010 for a dental	W	312			
	evidence his Ativar as part of an integr	ew on 5/20/2011 at 15 p.m. revealed there was no 15 p.m. revealed there was no 16 prescription was being used 16 plan to reduce his 16 plance with meeting medical 17 plance with meeting medical 17 plance with meeting medical 17 plance with meeting medical 18 plance with meeting with meeting medical 18 plance with meeting with with meeting with meeting with meeting with with with meeting with with with with with with with wi		en er en			
	facility 's licensed Qualified Intellectu (QIDP) on 5/20/20 confirmed, there waddress his behaviaddition, the physic	er record review with the practical nurse (LPN) and the al Disability Professional 11 at approximately 12:10 p.m. as nothing else in place to or besides the medications. In cian 's orders for the 1/18/2010 sedation's were not of survey.					
W 368	an integral plan to complete his medi	o ensure the implementation of manage Client #1 's inability to cal appointments.  JG ADMINISTRATION	W	368			

Event ID: M35E11

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/14/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0							
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G160	B. WING		05/20/2011		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 78 53RD PLACE, SE			
WHOLIST	TIC 07			WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION		
W 368	that all drugs are a the physician's ordinate physician's ordinate physician's ordinate physician's ordinate physician's ordinate physician's ordinate physician physi	g administration must assure dministered in compliance with ers.  is not met as evidenced by: tion, staff interview and record failed to ensure client 's ications as prescribed for two lients. [Clients #2 and #3]  is:  o ensure all medications were rescribed and failed to ensure ersight of all client 's sure health and safety as  on 5/19/2011 at 11:25 a.m. was prescribed "Hydralazine; 1 tab by mouth every 8 hours ise)." Further record review y was not maintaining a ting of the "noon" dosage of his day treatment program. It ed that Client #2 's day is not an outside service and services are also governed by rd review with the facility 's (RN) on 5/19/2011 at 5:17 p.m. ralazine was not administered non 6/8/2010, 12/1/2010,	W 368	internal systems widured monthly of mare is to extend according to extend admir Haring forward, will complete, in notes, an audit warm medication record that all proceed relianced according medications been missed.  Residential and proceed residential and medication are trained importance of the documentation are documentation are communication and mare in medicated abserved and gas is med	reviews sure rate instration nurses monthly of administ ho ensure sures are gly and house Day b/14/11 se houe on the innely id		
	Registered Nurse confirmed the Hyd at the day program 12/27/2010 and 12	(RN) on 5/19/2011 at 5:17 p.m. ralazine was not administered			of-		

Client #2 was absent from the day program on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G160	B. WII	NG		05/2	0/2011
NAME OF P	ROVIDER OR SUPPLIER			78	EET ADDRESS, CITY, STATE, ZIP CODE 8 53RD PLACE, SE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CDRRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 368	home or having to Further interview of approximately 5:20 also failed to ensur administered by the question.  2. Record review revealed Client #3 300mg Capsule, 1 split noon dose)." revealed the facility consistent account this medication at I should also be note treatment program.	attend a medical appointment. In the same day at p.m. confirmed, the facility e the Hydralazine was e home on the days in  on 5/19/2011 at 5:00 p.m. was prescribed "Carbatrol SA Cap by mouth 3 x a day (D/W Further record review was not maintaining a ing of the "noon" dosage of his day treatment program. It ed that Client #3's day is not an outside service and services are also governed by	W	368			
W 440	Registered Nurse (confirmed the Cark the day program of 8/2/2010, 8/3/2010 and 6/28/2010. Ac day and time with tabsent from the day questions due to have appointment. Furtat approximately 5 also failed to ensure administered by the questions.  483.470(i)(1) EVA	rd review with the facility 's (RN) on 5/19/2011 at 5:33 p.m. patrol was not administered at 12/8/2010, 12/9/2010, 8/6/2010 ditional interview on the same the RN revealed, Client #2 was by program on the days in 10 meither being at home, on to attend a medical ther interview on the same day 38 p.m. confirmed, the facility re the Carbatrol was e home on the days in CUATION DRILLS	W	440			
	. The tacility must fi	OLD CAMONOMICH CHIEF OF LOGGE		•	<u> </u>		<u> </u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	09G160	B. WING		05/20	2011
NAME OF PROVIDER OR SUPPLIED WHOLISTIC 07		78	EET ADDRESS, CITY, STATE, ZIP 53RD PLACE, SE ASHINGTON, DC 20019		
DRICKY /FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	(X5) COMPLETION DATE
· · · · · · · · · · · · · · · · · · ·	shift of personnel.	W 440	Drills are sche quarterly pursu a calender ye find schedule	duled want to	
Based on staff in facility failed to e evacuation drills (quarter) to ensu clients residing in	is not met as evidenced by: interview and record review, the insure all three shifts took part in over the past three months ire the health and safety of all in the facility during emergent its #1, #2, #3, #4 and #5]		a calender ye find shedule	adached.	
approximately 9: drills on record for	des: e drill logs on 5/19/2011 at 30 a.m. revealed there were no or the a.m. to 4:30 p.m. shift e months period covering 2/2011				
Professional (QI approximately 3: following the schoutlines when the Upon further instance were no 8:	e Qualified Intellectual Disability DP) on 5/20/2011 at 30 p.m. revealed he was eduled fire drill policy which e drills should be conducted. pection, the QIDP confirmed 00 a.m4:30 p.m. drills e three months period covering 11.				
in a manner to e at least quarterly W 441 483.470(i)(1) EV	ACUATION DRILLS  hold evacuation drills under	W 441	Fire dill sch Implemented June 1st 2011 greater vario in schedu	reflects	6/1/11

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	C TOD MEDICAPE	& MEDICAID SERVICES	OMB NO. 0938-0391					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTI	ON	(X3) DATE SURVEY COMPLETED		
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMIT		
		09G160	B WING			05/	20/2011	
NAME OF P	ROVIDER OR SUPPLIER				ITY, STATE, ZIP COD	E		
WHOLIS	TIC 07			53RD PLACE, S ASHINGTON,				
					DER'S PLAN OF COR	RECTION	(X5)	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	/EACH CO	DRRECTIVE ACTION ( FERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
	Based on staff interfacility failed to ensist scheduled or imple conditions to ensure clients residing in the situations. [Clients of the finding include of the eight hour blocked to cover 1 p.m., and 4 p.m. to the HM, the same mirrored over the will be drills were being or 4:30 p.m. for the 4/2011.  In addition, the fire accurate usage of twelve months. The available at the time that either the secondary existing the drills were bessement exit documents.	is not met as evidenced by: erview and record review, the sure all fire drills were emented under varying re the health and safety of all the facility during emergent #1, #2, #3, #4 and #5] es: W440) facility's House Manager (HM) porpximately 9:55 a.m., y's staffing patterns consisted shifts per day. The shifts were 2 a.m. to 8 a.m., 8 a.m. to 4 to 12 a.m. daily. According to staffing pattern was also	W 441	have been the of varied daining	thon sto correct ed egress and do drills to expls we doubt.	uned implements s to currents s ensure ce used	6/29/11	
		Qualified Intellectual Disability P) on 5/20/2011 at						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	.,, ,		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	09G160	B. WIN	۷G		05/20	/2011
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 07			STREET ADDRESS, CITY, STATE, ZIP CODE 78 53RD PLACE, SE WASHINGTON, DC 20019			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
logs that were failed to reflectime and egre.  The facility fail drills allowed for to time and egre.  W 460 483.480(a)(1) SERVICES  Each client modell-balanced specially-presentation of three serview, the fact received their two of three serview, the fact received their their meals in dietary orders.  1. Observation approximately served a meanure served a meanure served of the service of wheat bowl of mixed different than record review revealed his 5	3:35 p.m. confirmed the fire drill available at the time of survey to varying conditions with regards to see points.  ed to ensure the scheduling of fire or varying conditions with regards ress points.  FOOD AND NUTRITION  ast receive a nourishing, diet including modified and cribed diets.  RD is not met as evidenced by: ervation, staff interview and record cility failed to ensure clients meals in the manner prescribed for ampled clients. [Clients #1 and #2]				to atary  conduct  months  vidinte	

PRINTED: 06/14/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	COMPLETED	
	09G160	B. WING		05/2	20/2011
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 07		78.5	ET ADDRESS, CITY, STATE, ZIP COI 13RD PLACE, SE SHINGTON, DC 20019	DE	
PRIETY /FACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
dinner time. " This of 12/8/2010. Client #2 offered or provided dinner on the evenir Interview with the fa (RN) on the same d p.m. confirmed, the was correct and that offered Client #2 as 2. Observation on approximately 5:00 preparing the meal cooking sauces prior stove. The smell of aromatic and filled to the meal. Further of 6:05 p.m. revealed of rice, sautéed onic wheat bread, a cup mixed fruit. Neither content of the meal else's at the table.  Record review on 5 revealed his 5/2011 prescribed his meal low fat, bland and horder was put into else was not observed to bland diet " during 5/17/2011.  Interview with the fat (RN) on the same of the	ed salt, double portions at order was put into effect on 2 was not observed to be "double portions" during and of 5/17/2011.  cility 's Registered Nurse ay at approximately 12:05 "double portions" order the staff should have at least second serving of his meal.  the evening of 5/17/2011 at p.m. revealed the staff seasoned the meat and the or to placing them on the the seasoning was very he home as the staff prepared bservations on the same day Client #3 was served a portion ons, ground beef, a slice of of fruit juice and a bowl of the serving size nor the was any different than anyone /19/2011 at 10:57 a.m.	W 460			

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>			VAL DATE SI	DVEY
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		09G160	B. WI	NG		05/20	/2011
NAME OF P	RDVIDER OR SUPPLIER			70	EET ADDRESS, CITY, STATE, ZIP CODE 8 53RD PLACE, SE VASHINGTON, DC 20019		
					PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
W 460	Continued From pa	age 10	w	460			
VV 400		e staff should have ensured	,,				
	Client #3 received					;	
W 474	483.480(b)(2)(iii) M		W	474	۱	<b>.</b> _	
VV 4/4	400.400(b)(2)(m) iv				Staff have been hor h	<b>΄</b> Α	1 1-11
	Food must be serv	red in a form consistent with the			orac h	1460	62411
	developmental leve	el of the client.			ictrained for		
	Based on observa	is not met as evidenced by: tion, staff interview and record failed to ensure client 's					
		is in the form and texture of two sampled clients.					Martin Carrier Communication C
	The finding include	<b>9</b> \$:					- The Constant of the Constant
	Client #1 and #3 w apples (Granny Sr	17/2011 at 4:45 p.m. revealed, rere served a snack of sliced nith apple) and a cup of fruit s appeared firm and made a lient bit into it.					
	5/2011 physician '5/12/2011 at 4:27 prescribed a " me texture diet. Revieur physician 's order	1 's nutritional assessment and s order sheets (POS) on p.m. revealed he was achanically soft chopped "ew of Client #3 's 5/2011 sheets on 5/19/2011 at 11:06 was prescribed a "chopped"					
	Disability Profession Nurse (RN) on 5/1 p.m. confirmed, the was correct and the	facility 's Qualified Intellectual onal (QIDP) and the Registered 9/2011, at approximately 12:05 ie "chopped" texture order nat the staff should have nts #1 and #3 received the					

#### PRINTED: 06/14/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 05/20/2011 09G160 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 78 53RD PLACE, SE WHOLISTIC 07 WASHINGTON, DC 20019 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 474 W 474 : Continued From page 11 apples in a chopped texture. The facility failed to ensure all clients received their meals in the prescribed texture requirement to ensure their health and safety during meals.

Health Regulation & Licensin	ng Administration				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  HFD03-0147		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2011	
	NFD03-0147	CTDEET ADD	DESS CITY S	STATE, ZIP CODE	00/20/2011
NAME OF PROVIDER OR SUPPLIER	į			STATE, EN CODE	
WHOLISTIC 07			TON, DC 2		
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5/17/2011 through sampling of three members and physics. The findings of this observations at the programs, interview management, and administrative reconscident reports.  I 183 3508.4 ADMINISTE Each GHMRP shall who meets the requisional manage the Gapproved policies at This Statute is not Based on observations.	ey was conducted from 5/20/2011. A randor esidents was selected dividuals with varying ical disabilities.  survey were based of group home and two with direct care staff a review of the habilities including the unusual RATIVE SUPPORT. I have a Residence Duirements of § 3509.76 HMRP in accordance.	on day fand and who e with	1000	Staff have been to to ensure proper i of man preparate include texture and pursuant to Individe dietary orders.	e-trained 6/2011 mplementation ion to d form
(QIDP) coordinated services, for two of (Residents #1 and  The findings includ  The facility 's Qual Professional (QIDF) effectively trained to	e: ified Intellectual Disa r) failed to ensure all o serve meals in the d. (See Federal Defi	nitored esidents. bility staff were texture		Periodic training in to ensure dictary are being adhered Scheduled for every see attached.	requirements to.
1 229 3510.5(f) STAFF T	RAINING	engelige ( ) — ( )	1229		

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIES REPRESENTATIVE'S SIGNATURE

COMPCIANCE SUPERNUOR 6/2411

Health Re	gulation & Licensin	g Administration					T	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  05/20/2011		
		HFD03-0147	<u></u>				05/2	0/2011
NAME OF PR	OVIDER OR SUPPLIER				TATE, ZIP CODE			
WHOLISTIC 07 78 53RD P WASHING			LACE, SE TON, DC 20					
(X4) ID - PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL ,	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTIVE ACTION SHO NGED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
1 229	Continued From pa	ige 1		1229		•		
	Each training progr limited to, the follov	am shall include, but ving:	not be					
; .	residents to be sento, behavior manag	related to the GHMR ved including, but not rement, sexuality, nut mmunications, and a	limited rition,					
	Based on observation observation of the comment of	met as evidenced by ion, staff interview an ne for Persons with Ir i) failed to ensure all o provide resident 's er prescribed by the pwo of three sampled #3]	d record tellectual staff was their orimary					
	The findings includ	<b>e</b> :	1					:
:	The facility failed to their meals in acco dietary orders as io	ensure all residents rdance with their pre- lentified below:	received scribed		See I	183		61294
	approximately 6:00 was served a meal slice of wheat brea bowl of mixed fruit.	n the evening of 5/17/ p.m. revealed Resid of rice, onions, grou d, a cup of fruit juice His serving size wa ne else at the table.	ent #2 nd beef, a and a			·		
	revealed his 5/201° prescribed his mea cholesterol, no add dinner time. "This 12/8/2010. Reside	5/19/2011 at 11:57 a. 1 physician 's orders als be served, "low led salt, double portio order was put into e ant #2 was not observ "double portions" ing of 5/17/2011.	ons at ffect on red to be					

Health F	Regulation & Licensin	g Administration					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		HFD03-0147		B. WING		05/2	20/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
			PLACE, SE GTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	IO PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
1 229	Continued From pa	ige 2		1229			:
	(RN) on the same of p.m. confirmed, the was correct and the offered Resident #2  2. Observation or approximately 5:00 preparing the meal cooking sauces pristove. The smell of aromatic and filled the meal. Further 6:05 p.m. revealed portion of rice, sautislice of wheat breat bowl of mixed fruit.	acility's Registered I day at approximately e'double portions" at the staff should ha 2 a second serving of the evening of 5/17/ p.m. revealed the st seasoned the meat or to placing them on f the seasoning was the home as the staff observations on the s Resident #3 was ser teed onions, ground I d, a cup of fruit juice Neither the serving neal was any different he table.	12:05 order ve at least f his meal. 2011 at aff and the very f prepared same day ved a beef, a and a size nor				
	revealed his 5/201; prescribed his mea low fat, bland and h order was put into 6; #3 was not observe	5/19/2011 at 10:57 a. 1 physician 's orders als be served, "low s nigh fiber, chopped di effect on 4/6/2011. F ed to be offered or pr ng dinner on the even	odium, iet. " This Resident ovided "				
	(RN) on the same of p.m. confirmed, the	acility 's Registered l day at approximately e " bland diet " order e staff should have er ed a bland meal.	12:05 was				
	revealed, Resident snack of sliced app	n 5/17/2011 at 4:45 p #1 and #3 were serviles (Granny Smith a n. The apples appea	red a pple) and				

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 05/20/2011 HFD03-0147 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 78 53RD PLACE, SE WHOLISTIC 07 WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE IEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1229 1229 Continued From page 3 and made a crunch when the resident bit into it. Review of Resident #1 's nutritional assessment and 5/2011 physician 's order sheets (POS) on 5/12/2011 at 4:27 p.m. revealed he was prescribed a " mechanically soft ... chopped " texture diet. Review of Resident #3 's 5/2011 physician's order sheets on 5/19/2011 at 11:06 a.m. revealed he was prescribed a "chopped" texture diet. . Interview with the facility 's Qualified Intellectual Disability Professional (QIDP) and the Registered Nurse (RN) on 5/19/2011, at approximately 12:05 p.m. confirmed, the "chopped" texture order was correct and that the staff should have ensured both Residents #1 and #3 received the apples in a chopped texture. The facility failed to ensure all residents received their meals in the prescribed texture requirement to ensure their health and safety during meals.

M35E11

Health Regulation & Licensin	g Administration				<del></del>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	HFD03-0147		B. WING		05/2	0/2011	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
78 53RD P			PLACE, SE STON, DC 20019				
PREELY (FACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL :	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
R 000 INITIAL COMMEN		way ido of DemandrateFirst	R 000				
5/17/2011 through sampling of three r	ey was conducted fro 5/20/2011. A randon esidents was selecte ndividuals with varying ical disabilities.	m d from a					
observations at the programs, interview management, and	survey were based of group home and two with direct care state a review of the habilitate including the unu	day ff and tation and					
R 125 4701.5 BACKGROUND CHECK REQUIREMENT			R 125				
criminal history of to contract worker for in all jurisdictions we employee or contra	round check shall dis the prospective emplo the previous seven ( within which the prosp act worker has worke seven (7) years prior	oyee or (7) years, pective					
Based on record re facility failed to pro background check and residence hist	t met as evidenced by eview and staff intervivide evidence that cr s covered the seven ory of each staff prior of for two (2) out of the	iew, the iminal year work to their					
The finding include	es:						
Qualified Intellectu (QIDP) on 5/19/20 confirmed the folio	I interview with the G ial Disability Profession 11, at approximately wing deficient practic	onal 4:30 p.m., ces:		·			
:	ords reflect they eithe	r lived or					
Health Regulation & Licensing Admir	nistration	•		TITLE		(X8) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Supervisor

f continuation sheet 1 of 2

Health Regulation & Licensing Administration								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED				
HFD03-0147				05/20/2011				
	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE					
Y MUST BE PRECEDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE COMPLETE				
of Pennsylvania with the screening, but the discheck only covered rds reflect they either of North Carolina with the screening, but the discheck only covered	he I the state lived or thin the he I the state		staff # 1 vidus  PA. Results were  separate sheet in  n personnel folk  Ser attachment	on a rounded ers.  Simple on 6/18/11  range  rer				
			Freuse note, 3 creation staff # was completed parior of 5 and inserted in performance of 5/16/11 procedures	somel er				
	HFD03-0147  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY MUST BE PRECEDED BY SC IDENTIFYING INFORMATION OF THE SCREENING, but to the screening, but the screening the scree	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0147  STREET ADD 78 53RD F WASHING  ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0147  STREET ADDRESS, CITY, S 78 53RD PLACE, SE WASHINGTON, DC 20  ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  Age 1  of Pennsylvania within the to the screening, but the ad check only covered the state  ords reflect they either lived or to of North Carolina within the to the screening, but the did check only covered the state  ords reflect they either lived or to of North Carolina within the to the screening, but the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is to the did check only covered the state of the screening is	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0147    STREET ADDRESS, CITY, STATE, ZIP CODE				